SPSP Acute Adult Programme Sepsis Change Package

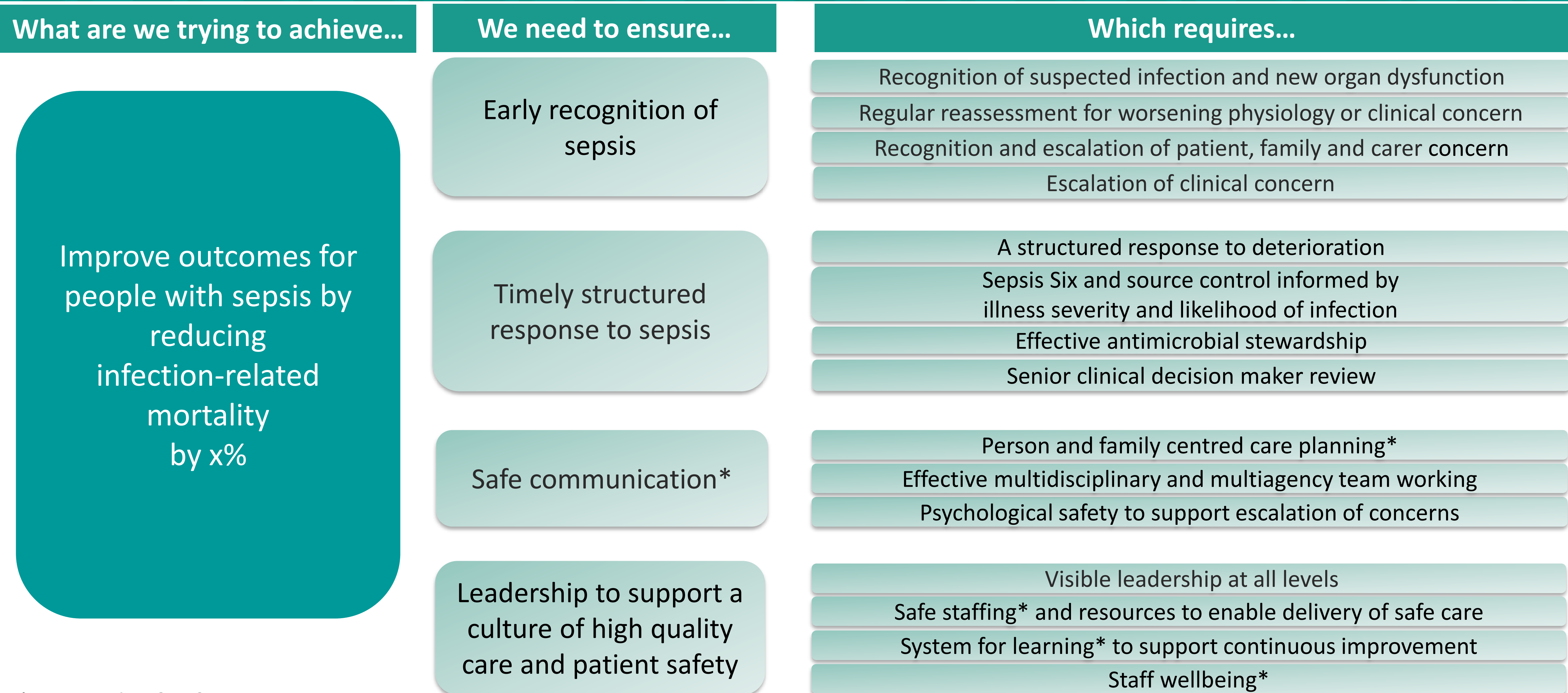
2023

NHS
SCOTLAND

Sepsis Driver Diagram 2023

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME



*Essentials of Safe Care

Primary Driver
Early recognition of sepsis

Secondary drivers	Change ideas			
Recognition of infection and new organ dysfunction	Use of NEWS2 to identify deterioration and organ dysfunction	Process to determine likelihood of infection, e.g. AoMRC decision making framework	Use of electronic observations to support clinical decision making	Process to identify variation in presentation, e.g. considerations of ethnicity in pulse oximetry, deterioration in optimal posture
Regular reassessment for worsening physiology or clinical concern	NEWS2 charting allows documentation of clinical judgement that may alter frequency of observations	Patients, families, and carers are given advice to support identification of further deterioration	Local process to proactively identify and reassess people at higher risk of deterioration, e.g. neutropenia	Patient, family and carer view of illness and concerns consistently sought e.g. asking 'how well are you feeling compared to the last time we asked you?'
Recognition and escalation of patient, family and carer concern	Provision of accessible information to patients, families, and carers to support early recognition and access to treatment in sepsis	Process for patients, families, and carers to raise concerns about acute deterioration	Locally agreed process for staff to document and escalate concerns raised by patients, families and carers	Process to reliably provide feedback to the person who raised concern
Escalation of clinical concern	Locally agreed escalation framework that incorporates clinical concern	Reliable notification of deterioration to consultant in charge of patient's care	Reliable timely triage of people with sepsis including in transition from NHS24, primary care, and SAS	Consider system-wide escalation mechanisms e.g. outreach team, electronic NEWS2 and decision support

Primary Driver
Timely structured response to sepsis

Secondary drivers	Change ideas				
A structured response to deterioration	Locally agreed standardised approach to structured response to deterioration	Shared decision making supported by access to any existing future care plan	Locally agreed criteria for completion of person centred TEP	Reassessment criteria documented as part of management plan e.g., worsening NEWS2 despite treatment	
Sepsis Six and source control informed by illness severity and likelihood of infection	Use of AoMRC decision making framework to support timely delivery of Sepsis Six	Process to ensure assessment for source control and implementing any source control interventions in a timely manner	Collection of appropriate samples for infection investigations, including blood cultures, prior to first antimicrobial	Clinical assessment considers non-bacterial causes (e.g. viral infection) and associated de-escalation	
Effective Antimicrobial stewardship	Process to establish true allergy status to maximise opportunity for first line antimicrobials	Antimicrobial plan documented in clinical notes, HEPMA and handover	Daily antimicrobial review informed by clinical assessment and microbiology results	Antimicrobials prescribed in line with local guidance, severity, and relevant past medical history	Daily antimicrobial review considers IV-Oral Switch Therapy (IVOST) in line with local guidance
Senior clinical decision maker review	Local escalation processes enable early involvement of a senior clinical decision maker	Locally agreed process for critical care review	Consultant review at least daily and within 14hrs of hospital admission	Local escalation processes set out who to contact and when	

Primary Driver
Safe communication*

Secondary drivers	Change ideas				
Person and family centred care planning	Existing complex care plans, e.g. patient passports, used to inform acute care planning	Locally agreed process to understand pre-hospital baseline	Use of 'what matters to you' approach to plan and deliver care	Use of the word 'sepsis' in person centred conversations at point of deterioration	Documented person centred discussion with patient and family about recovery trajectory and rehabilitation planning
Effective multidisciplinary and multiagency team working	Patients of concern identified during board rounds, unit safety briefs and hospital huddles	Structured handovers within and between teams e.g. use of SBAR	Process for engaging all specialist and community teams involved in the person's care, e.g. social work, home care	Clarity of team roles and responsibilities in the care of a deteriorating patient	
Psychological safety to support escalation of concerns	Processes to support a culture which supports staff and students to raise concerns	Process for managers at all levels to effectively recognise and respond to patient safety concerns	Promotion of Speak Up advocates and ambassadors to encourage staff to raise concerns	Process to reliably provide feedback to the person who reported concern	

Primary Driver
Leadership to support a culture of safety

Secondary drivers	Change ideas			
Visible leadership at all levels	Conduct and share learning from leadership walkrounds	Opportunity for senior leaders to review sepsis related data and trends	Access to clinical and improvement leadership time to support sepsis improvement work	Sepsis improvement work aligns with organisational priorities
Safe staffing and resources to enable delivery of safe care	Identify and mitigate staffing needs using real time staffing tools, including acuity assessment	Process to escalate staffing shortfalls	Education and induction includes local processes for early recognition and response for sepsis	Identify and mitigate time periods where escalation response is less reliable
System for learning to support continuous improvement	Collect, share, and act on data and learning between teams, hospitals, and boards	Identify and share learning through existing processes e.g. MDT morbidity and mortality meetings	Structured process for multidisciplinary hot and cold debriefs	Forums for staff, patients and families, to identify areas for improvement
Staff wellbeing	Use of effective health and wellbeing conversations to identify and mitigate risks to wellbeing	Prioritise civility through communication and teamwork, e.g. use of TeamSTEPPS	Support job satisfaction through evidence based interventions, e.g. Professional Identity Development Programme	Access to senior support and discussion for all staff, e.g. through clinical supervision